| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| HORIZON HEALTH AND REHAB CENTER | 811 KEYLON STREET MANCHESTER, TN 37355 |

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| F 000 | INITIAL COMMENTS<br><br>A Recertification survey and investigation of complaint #38011 was conducted from 3/7/16 through 3/9/16, at Horizon Health and Rehab Center. No deficiencies were cited in relation to complaint #38011, under CFR PART 483, Requirements for Long Term Care Facilities. | F 000 | "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Horizon Health and Rehabilitation does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the dish machine manufacturer's recommendations, the facility failed to maintain dietary equipment in a sanitary manner, failed to serve food in a sanitary manner for 4 of 10 trays and failed to ensure the dish machine sanitizer level was within the manufacturer's recommendation level.<br><br>The findings included:<br><br>Observation on 3/7/16 at 5:12 AM and on 3/8/16 at 8:35 AM, in the dietary department, and interview with the dietary cook present, confirmed the grill surface, and the interior and exterior | F 371 | 1. **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>The grill surface and the interior and exterior sides of the grill were cleaned on 3/23/16.<br><br>Improper food handling was immediately stopped upon observation after the 4th tray and the dietary cook was in-serviced by the Dietary Manager on 3/7/16 to use gloves and/or tongs.<br><br>The sanitizer level of the dish machine was checked on 3/8/16.<br><br>The filter over the fryer was cleaned on 3/23/16.<br>The shelf under the preparation table was cleaned on 3/23/16. | 4-23-16 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Robin Crowell by DMyhett 3/31/16 | CEO, LNHA | 3/25/16 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 371 | Continued From page 1<br>sides had a heavy black accumulation of debris. Further interview revealed the grill was not used for cooking.<br><br>Observation on 3/7/16 at 6:35 AM in the dietary department, with the dietary manager present, revealed the resident morning meal tray line was in process. Further observation revealed the dietary cook serving the food, touching the biscuit, bacon, and orange slice with the same gloved hand for 4 of 10 trays, thereby possibly contaminating the food.<br><br>Interview with the cook and dietary manager on 3/7/16 at 6:45 AM confirmed the cook had been touching 3 separate food items with the same gloved hand.<br><br>Observation on 3/8/16 beginning at 8:27 AM in the dietary department dish room, and interview with the dietary manager and/or cook present, revealed the dish machine was in operation. Review of the manufacturer's recommendations posted on the dish machine revealed the sanitizer level was to be at least 50 parts per million for chlorine. When the dietary manager was asked to have the sanitizer level checked, the manager stated the chemical company checked the machine monthly. Interview with the cook, at the time of the observation, stated the dish machine was new and in place for perhaps the last 6 months. Further interview with both the manager and the cook, revealed the dietary staff did not and had not checked the sanitizer level of the dish machine since the machine's installation and there were no test strips available to check it. Review of the chemical company monthly visit documentation revealed the sanitizer level was or exceeded 75 parts per million. Interview with the | F 371 | **2. How the facility will identify other residents having the potential to be affected by the same deficient practice.**<br><br>All residents have the potential to be affected.<br><br>On 3-8-16, sanitation strips were obtained and immediate testing began and sanitation strips are now being used with each dish cycle<br><br>An Eco-lab technician initiated an in-service via phone conference on 3-8-16 on checking sanitization levels for the dish machine for dietary employees. This in-servicing was completed in person on 3/14/16 for all dietary employees.<br><br>Cleaning schedule is posted with daily and weekly assignments. Deep cleaning of the kitchen is done on a daily continuous basis. | 4-23-16 |

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| F 371 | Continued From page 1<br>sides had a heavy black accumulation of debris. Further interview revealed the grill was not used for cooking.<br><br>Observation on 3/7/16 at 6:35 AM in the dietary department, with the dietary manager present, revealed the resident morning meal tray line was in process. Further observation revealed the dietary cook serving the food, touching the biscuit, bacon, and orange slice with the same gloved hand for 4 of 10 trays, thereby possibly contaminating the food.<br><br>Interview with the cook and dietary manager on 3/7/16 at 6:45 AM confirmed the cook had been touching 3 separate food items with the same gloved hand.<br><br>Observation on 3/8/16 beginning at 8:27 AM in the dietary department dish room, and interview with the dietary manager and/or cook present, revealed the dish machine was in operation. Review of the manufacturer's recommendations posted on the dish machine revealed the sanitizer level was to be at least 50 parts per million for chlorine. When the dietary manager was asked to have the sanitizer level checked, the manager stated the chemical company checked the machine monthly. Interview with the cook, at the time of the observation, stated the dish machine was new and in place for perhaps the last 6 months. Further interview with both the manager and the cook, revealed the dietary staff did not and had not checked the sanitizer level of the dish machine since the machine's installation and there were no test strips available to check it. Review of the chemical company monthly visit documentation revealed the sanitizer level was or exceeded 75 parts per million. Interview with the | F 371 | **3. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.**<br><br>An Eco-lab technician initiated an in-service via phone conference on 3-8-16 on checking sanitization levels for the dish machine for dietary employees. This in-servicing was completed in person on 3/14/16 for all dietary employees.<br><br>The Dietary Manager in-serviced 100% of dietary staff on the Preventing Foodborne Illness – Food Handling policy and procedure which included handwashing, using gloves, and tongs and this in-servicing was completed on 3-22-16.<br><br>A Dish Machine Sanitization Log was developed and utilization of this log began on 3/9/16 to document compliance of sanitization testing of the dish machine. The Dietary Manager will document compliance 5x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure compliance.<br><br>On 3/23/16, the grill surface and under the prep table were added to the dietary daily cleaning schedule and fryer filters were added to the weekly cleaning schedule.<br><br>The Dietary Manager will document compliance of safe handling of food 5x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure compliance. | 4-23-16 |

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| F 371 | Continued From page 2<br>facility Administrator on 3/8/16 at 9:45 AM in the hall outside the Director of Nursing office, revealed the dish machine had been installed in August 2015.<br><br>Observation on 3/8/16 at 8:35 AM in the dietary department, and interview with the cook and dietary manager present, confirmed the shelf over the grill had an accumulation of smeared food debris, and the filter positioned over the fryer had a greasy residue. Further interview with the cook revealed the cook had not placed anything on the shelf above the grill while he was cooking that day. Further observation and interview with the manager confirmed the shelf under the preparation table had rust and dried splattered debris present. Further interview confirmed the grill surface and exterior and interior sides had a heavy accumulation of black debris. | F 371 | **4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.**<br><br>The Administrator of Dietary Manager will present the audit results to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 4 months for further recommendations and/or follow up as needed. | 4.23.16 |
| F 456 SS=F | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br><br>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility dietary department failed to maintain 1 of 1 plate warmer and 3 of 3 walk-in refrigerators in a safe operating condition.<br><br>The findings included:<br><br>Observation on 3/7/16 at 5:12 AM and on 3/9/16 at 9:30 AM in the dietary department with the | F 456 | **F456**<br>**1. How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>Rust remover and paint ordered on 3/22/16. Refrigerator #3 will have rust removed and repainted by 3/30/16. Refrigerator #2 was taken out of commission on 3/24/16 and Refrigerator # 4 was taken out of commission on 3/21/16 and both will not be used. A gasket was ordered on 3/24/16 for the plate warmer and will be replaced by 3/30/16. | |

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| F 456 | Continued From page 3<br>dietary cook and/or dietary manager present, revealed walk-in refrigerators #2, #3 and #4 had rusted areas on the ceiling and walls. Further observation and interview confirmed in the walk-in refrigerator #4 the ceiling area to the right of the condenser had a visible gap; the rusted area above the condenser had hanging debris; and the door's exterior handle and surrounding area had an accumulation of sticky debris.<br><br>Observation on 3/7/16 at 6:35 AM in the dietary department during the resident morning meal service revealed the plate warmer lid had a gasket that was loose and failed to maintain a proper seal.<br><br>Interview with the dietary manager on 3/9/16 at 9:30 AM in the dietary department confirmed the plate warmer gasket was in disrepair. | F 456 | **2. How the facility will identify other residents having the potential to be affected by the same deficient practice.**<br><br>All residents have the potential to be affected.<br><br>Refrigerator #2 was permanently taken out of commission on 3/24/16 and #4 was permanently taken out of commission on 3/21/16 and both will not be used.<br><br>Only one plate warmer serves the facility and the gasket was ordered on 3/24/16 and will be replaced by 3/30/16.<br><br>Rust remover and paint ordered on 3/22/16. Refrigerator #3 will have rust removed and repainted by 3/30/16. | 4-23-16 |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced | F 514 | | |

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| F 456 | Continued From page 3<br>dietary cook and/or dietary manager present, revealed walk-in refrigerators #2, #3 and #4 had rusted areas on the ceiling and walls. Further observation and interview confirmed in the walk-in refrigerator #4 the ceiling area to the right of the condenser had a visible gap; the rusted area above the condenser had hanging debris; and the door's exterior handle and surrounding area had an accumulation of sticky debris.<br><br>Observation on 3/7/16 at 6:35 AM in the dietary department during the resident morning meal service revealed the plate warmer lid had a gasket that was loose and failed to maintain a proper seal.<br><br>Interview with the dietary manager on 3/9/16 at 9:30 AM in the dietary department confirmed the plate warmer gasket was in disrepair. | F 456 | **3. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.**<br><br>The Maintenance Director added the interior of the refrigerators and the plate warmer gasket to his monthly rounds inspecting for rust and/or areas of concern effective 3/25/16.<br><br>100% of dietary staff have been in-serviced on cleaning the kitchen by the Dietary Manager. This will be conducted by 3/22/16. The Dietary Manager will utilize a cleaning schedule and ensure this is being followed. The Dietary Manager will monitor this cleaning schedule 3x/week x 4 weeks, then weekly ongoing to ensure compliance with cleaning schedules. | 4-23-16 |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced | F 514 | | |

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| F 456 | Continued From page 3<br>dietary cook and/or dietary manager present, revealed walk-in refrigerators #2, #3 and #4 had rusted areas on the ceiling and walls. Further observation and interview confirmed in the walk-in refrigerator #4 the ceiling area to the right of the condenser had a visible gap; the rusted area above the condenser had hanging debris; and the door's exterior handle and surrounding area had an accumulation of sticky debris.<br><br>Observation on 3/7/16 at 6:35 AM in the dietary department during the resident morning meal service revealed the plate warmer lid had a gasket that was loose and failed to maintain a proper seal.<br><br>Interview with the dietary manager on 3/9/16 at 9:30 AM in the dietary department confirmed the plate warmer gasket was in disrepair. | F 456 | **4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.**<br><br>The Administrator or Director of Nursing will present the audit results to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further recommendations and/or follow up as needed. | 4-23-16 |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced | F 514 | **F514**<br><br>**1. How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>Resident #91's MAR audited for lack of documentation related to as needed medication on 3/9/16. Nursing staff not following policy and procedure for documentation requirements were given one on one in-servicing by 3/21/16 | |

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| F 514 | Continued From page 4<br>by:<br>Based on facility policy review, medical record review, and interview, the facility failed to maintain an accurate medical record for as needed medication for 1 (Resident #91) of 27 sampled residents.<br><br>The findings included:<br><br>Review of the facility policy, Documentation of Medication Administration, revised on 8/26/15, revealed "...Policy Statement...The facility shall maintain a medication administration record to document all medication administered..." Further review revealed the "...Policy Interpretation and Implementation...Documentation must include, as a minimum:...PRN [as needed] Medication: As needed medication: the individual administering the medication will record in the resident's medical record: The date and time the medication was administered; The dosage; The route of administration...Any complaints or symptoms for which the drug was administered; Any results achieved and when those results were observed; and The signature and title of the person administering the drug..."<br><br>Medical record review revealed Resident #91 was admitted to the facility on 2/19/16 with diagnoses including Cellulitis of Right Lower Limb, Muscle Weakness, Abnormality of Gait and Mobility, Lack of Coordination, Coronary Artery Bypass, Coronary Artery Disease, Recurrent Urinary Tract Infection, Hypertension, Gastro Esophageal Reflux, and Peripheral Arterial Disease.<br><br>Medical record review of the Physician's Orders dated 2/19/16 included the following PRN (as needed) medications: | F 514 | **2. How the facility will identify other residents having the potential to be affected by the same deficient practice.**<br><br>All residents have the potential to be affected.<br><br>The Director of Nursing completed an audit of all resident charts for PRN (as needed) medication orders on 3/21/16.<br><br>Residents who are receiving prn (as needed) medication were reviewed for scheduled pain medication administration on 3/21/16. | 4-23-16 |

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| F 514 | Continued From page 5<br>1.) Xanax (anti-anxiety) 0.5 mg (milligrams) po (by mouth) TID (3 times daily).<br>2.) Norco (pain medication) 10 mg-325 mg 1 tablet po q (every) 8 hours.<br>3.) Acetaminophen 325 mg po take 2 tablets QID (4 times daily) for fever or pain.<br><br>Interview with the Director of Nursing (DON) on 3/9/16 beginning at 10:30 AM in the Administrator's office, when asked if nurses administered an as needed (PRN) medication, what she expected the nurses to document and where, the DON stated the nurses were to initial the front of the Medication Administration Record (MAR) as administering the medication. Further interview revealed the back of the MAR was to be filled out when the PRN medication was administered to include the date and time, name of the medication, the dosage, the reason for administering the medication and 30 minutes after the administration the effectiveness of the medication with the time and initials of the nurse per the facility policy.<br><br>Medical record review of the 2/2016 MAR and interview with the DON on 3/9/16 beginning at 10:30 AM in the Administrator's office confirmed the following:<br>1.) Xanax included administration on "...2/20 x 2...2/23 x 1...2/25 x 1...2/27 x 2..." The back of the MAR Nurse's Medication Notes included the Date/Hour, Medication/Dosage, Reason, and Results/Response as: on 2/20 x 1 (although was documented as administered x 2) and failed to have documentation addressing the effectiveness; on 2/23 failed to have documentation addressing the x 1 administration; on 2/25 x 2 (although was documented as administered x 1) and failed to have | F 514 | **3. What measure will be put in place or systemic changes made to ensure the deficient practice does not recur**<br><br>The Nurse Educator or Director of Nursing will in-service 100% of current licensed nursing staff by 3/21/16 to ensure all PRN (as needed) medication consists of the documentation as outlined in the Medication Administration policy and procedure to include date, time, dosage, route, site (if applicable), symptoms for which the drug is being administered, and results with signature and title of the person administering the drug.<br><br>The Director of Nursing will do a random audit of 10 residents weekly x 8 weeks, then biweekly x 4 weeks, then monthly x 1 month for PRN (as needed) medication administration documentation compliance. | 4-23-16 |

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| F 514 | Continued From page 6<br>documentation addressing the effectiveness for 10:00 AM; and on 2/27 failed to have documentation addressing the 2 administrations.<br>2.) Norco included administration on "...2/19 x 1, 2/21 x 2...2/22 x 3, 2/23 x 3..." The back of the MAR revealed on 2/19 no documentation for the x 1 administration; on 2/21 x 1 although was documented as administered x 2; on 2/22 failed to document the effectiveness for the 7:00 AM administration; and on 2/23 x 2 although was documented as administered x 3.<br><br>Medical record review of the 3/2016 MAR and continued interview with the DON on 3/9/16 beginning at 10:30 AM in the Administrator's office confirmed the following:<br>1.) Xanax included administration on "...3/2 x 2...3/5 x 2, 3/6 x 1..." The back of the MAR revealed on 3/2 x 1 although was documented as administered x 2, on 3/5 failed to document the effectiveness of the 10:00 AM administration; and on 3/6 x 2 although was documented as administered x 1.<br>2.) Norco included administration on "...3/1 x 1...3/3 x 2, 3/4 x 2, 3/5 x 1..." The back of the MAR revealed on 3/1 failed to document the effectiveness of the x 1 administration; on 3/3 failed to document the effectiveness of the 6:00 AM administration; on 3/4 failed to document the effectiveness of the 12:30 AM administration; and on 3/5 x 2 although was documented as administered x 1.<br>3.) Acetaminophen included no documentation of administration in March 2016. The back of the MAR revealed on 3/4/16 Acetaminophen (Tylenol) at 5:00 PM 650 mg for complaint of a head ache and at 6:30 PM "effective".<br><br>Continued interview with the DON on 3/9/16 | F 514 | **4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.**<br><br>The Administrator or Director of Nursing will present the audit results to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 4 months for further recommendations and/or follow up as needed. | 4-23-16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445383 | A. BUILDING _____ B. WING _____ | 03/09/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON HEALTH AND REHAB CENTER | 811 KEYLON STREET MANCHESTER, TN 37355 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 514 | Continued From page 7<br>beginning at 10:30 AM in the Administrator's office confirmed the facility failed to follow the policy to accurately document the number of administrations as well as the reason and/or effectiveness of the PRN medication administrations. | F 514 | | 4-23-16 |